STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION

IN RE: Courtland Gardens Health Center, Inc
53 Courtland Avenue
Stamford, CT 06902

MODIFIED CONSENT ORDER

WHEREAS, Courtland Gardens Health Center, Inc. (hereinafter the "Licensee"), has been issued License No. 1084 C to operate a Chronic and Convalescent Nursing Home known as Courtland Gardens Health Center, (hereinafter the "Facility") under Connecticut General Statutes Section 19a-490 by the Department of Public Health, State of Connecticut (hereinafter the "Department"); and

WHEREAS, the Facility Licensing and Investigations Section of the Department conducted unannounced inspections on various dates commencing on May 30, 2008 and concluding on June 12, 2008; and

WHEREAS, the Department, during the course of the aforementioned inspections identified violations of the Connecticut General Statutes and/or Regulations of Connecticut State Agencies were identified in a violation letter dated June 27, 2008 (Exhibit A – copy attached); and

WHEREAS, the Licensee executed a Consent Order with the Department on February 7, 2008 and is willing to enter into this Modified Consent Order and agrees to the conditions set forth herein.

NOW THEREFORE, the Facility Licensing and Investigations Section of the Department of Public Health of the State of Connecticut, acting herein by and through Joan Leavitt, Section Chief, and the Licensee, acting herein and through Lane Bowen, its President, hereby stipulate and agree as follows:

1. The Consent Order executed with the Department on February 7, 2008, (Exhibit B – copy attached) shall be incorporated and made part of this Modified Consent Order. The provisions of the Consent Order executed on February 7, 2008 are extended for a two (2) year period effective the date this modification is executed.
2. The Licensee shall be prohibited from admitting new patients into the facility with a diagnosis of dysphagia, however, patients sent to an acute care facility emergency department for evaluation or returning from an acute care hospitalization may be re-admitted to the facility.
3. The Licensee shall assess all current patients on modified diets for swallowing deficits and review applicable patient care plans and nurse aide assignments to ensure they accurately reflect the needs of the residents.
4. The Licensee shall in-service all direct care staff regarding feeding techniques for patients with swallowing deficits.

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WITNESS WHEREOF, the parties hereto have caused this Consent Order to be executed by their respective officers and officials, which Consent Order is to be effective as of the later of the two dates noted below.

COURTLAND GARDENS HEALTH CENTER - LICENSEE

7-8-08
Date

By: Lane Bowen
Lane M. Bowen, President

STATE OF UTAH)

County of SALT LAKE) ss JULY 8, 2008

Personally appeared the above named Lane M. Bowen and made oath to the truth of the statements contained herein.

My Commission Expires: 06/22/2011
(If Notary Public)

NOTARY PUBLIC
LAURA CHANDLER
7181 S. CAMPUS VIEW DR.
WEST JORDAN, UTAH 84084
COMMISSION EXPIRES
JUNE 22, 2011
STATE OF UTAH

Laura Chandler

Notary Public [X]
Justice of the Peace [ ]
Town Clerk [ ]
Commissioner of the Superior Court [ ]

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

July 11, 2008
Date

By: Joan D. Leavitt
Joan D. Leavitt, R.N., M.S., Section Chief
Facility Licensing and Investigations Section

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT A
PAGE 1 OF 4

June 27, 2008

Ms. Yvette Dobrak, Administrator
Courtland Gardens Health Cente
53 Courtland Ave
Stamford, CT 06902

Dear Ms. Dobrak:

Unannounced visits were made to Courtland Gardens Health Center which concluded on June 12, 2008 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by July 11, 2008 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

Please address each violation with a prospective plan of correction which includes the following components:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).

2. Date corrective measure will be effected.

3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

We do not anticipate making any practitioner referrals at this time.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Elizabeth Andstrom, RN, MS
Supervising Nurse Consultant
Facility Licensing and Investigations Section

ESA:bh

c. Director of Nurses
Medical Director
President
Complaint #CT7722, CT7291

Phone: (860) 509-7400
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12HSR
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

EXHIBIT A

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (o) Medical Records (2)(H).

1. Based on clinical record review and staff interview for one resident who required 1:1 assistance with eating (Resident #1), the assessment failed to accurately reflect the resident's status The findings include:
    a. Resident #1 had a diagnosis of dementia. The quarterly assessment dated 9/14/07 identified the resident was moderately cognitively impaired and required extensive to total assistance from staff for all activities of daily living (ADL's) including extensive assistance for feeding. The quarterly assessment dated 11/28/07 identified the resident was moderately cognitively impaired and required total dependence on staff for all ADL's except eating for which only set-up assistance was required. A nurse's note dated 9/10/07 at 6 PM identified Resident #1 was re-admitted from the hospital with diagnoses of E. Coli, urinary tract infection, diverticulitus, and severe dehydration. The hospital discharge orders dated 9/10/07 directed the resident be provided an advanced dysphagia diet and 1:1 assistance with eating. Nurse's notes further identified Physician #1 was notified of the hospital discharge orders. Interview and review of the clinical record on 6/5/08 at 4:00 PM with Minimum Data Set (MDS) Coordinator #1 identified that she believed Resident #1 required set-up only for eating, however she noted she had not conducted the assessment and was unable to explain the codings on the MDS. Interview and review of the clinical record on 6/5/08 at 3:30 PM with the Corporate Float Director of Nursing (DNS) identified the MDS Assessment dated 9/14/07 and 11/28/07 should have accurately reflected that the resident required total assistance with eating.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (o) Medical Records (2)(I).

2. Based on clinical record reviews and staff interview for two residents who required either an advanced dysphagia diet or attempted suicide (Resident #1, Resident #3), the facility failed to provide a comprehensive plan of care. The findings include:
    a. Resident #1 had a diagnosis of dementia. The quarterly assessment dated 6/14/07 identified the resident was moderately cognitively impaired and required extensive to total assistance from staff for all activities of daily living (ADL's) except eating for which the resident required supervision. A nurse's notes dated 9/10/07 at 6 PM identified Resident #1 was re-admitted from the hospital with diagnoses of E. Coli, urinary tract infection, diverticulitus, and severe dehydration. Hospital discharge orders dated 9/10/07 directed the resident be provided an advanced dysphagia diet and 1:1 assistance with eating. The re-admission nursing assessment dated 9/10/07 identified the resident required a dysphagia advanced diet, had chewing and swallowing problems, and required extensive assist for eating. The care plan dated 9/27/07 identified a potential for aspiration related to dysphagia and interventions included provision of a dysphagia diet,

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

however failed to identify the resident required 1:1 assistance with eating. The resident's care card dated 1/14/08 also failed to identify the resident's need for 1:1 assistance with eating. Interview and review of the clinical record on 6/5/08 at 3:30 PM with the Corporate Float Director of Nursing (DNS) noted the resident's need for 1:1 assistance with eating should have been identified as part of the plan of care.

b. Resident #3 had diagnoses of end stage liver disease, depression and anxiety disorder. The quarterly assessment dated 7/27/07 identified the resident was moderately cognitively impaired and required limited to extensive assistance from staff for all activities of daily living (ADL's). The care plan dated 9/24/07 identified disturbances in emotional status with increased paranoia. On 9/24/07 the resident was started on antipsychotic medication for increasing hallucinations. The nurses' notes dated 10/12/07 at 7AM and 10/13/07 at 2 PM identified the resident was having increased hallucinations and at 4:30 AM the Resident #3 locked herself in the bathroom, had taken out part of the screen, and was trying to open the window. The note further identified the resident was paranoid and combative. The resident was placed on 1:1 supervision and sent out to the Emergency Department for an evaluation. The hospital psychiatric evaluation report dated 10/14/07 at 7:10 AM identified Resident #3 had denied suicidal/homicidal intentions, however had impaired judgment due to delusions and recommended close monitoring of vital signs and Risperdal .5 mg by mouth at HS. Upon return to the facility, a physician's order dated 10/14/07 directed the resident receive psychiatric follow up and the resident's care plan was revised to include fifteen-minute checks. On 10/14/07 at 11 AM it was noted Resident #3 experienced increased hallucinatory behavior. The facility Incident Event Report dated 10/15/07 identified at 4:30 PM Resident #3 was found alert and confused in her room and had attempted to put a telephone cord around her neck. The resident was admitted to the hospital and returned to the facility on 10/22/07. The facility suicide policy identified the care plan for suicidal patients should include the resident's behavior, planned interventions, safety precautions, as well as the resident's level of emotional stability and/or suicide risk. Interview and review of the clinical record on 6/12/08 at 2:45 PM with the Corporate Regional Registered Nurse failed to provide documented evidence of a comprehensive care plan related to suicide.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (o) Medical Records (2)(H).

3. Based on clinical record review and staff interview for the only sampled resident who required an advanced dysphagia diet (Resident #1), the facility failed to ensure assessments were conducted after a re-admission. The findings include:
   a. Resident #1 had a diagnosis of dementia. The assessment dated 6/14/07 identified the resident was moderately cognitively impaired, required extensive to total assist for all activities of daily living (ADL's) except eating for which the resident required supervision. It further identified the resident had a chewing and swallowing problem.

EXHIBIT A

DATES OF VISIT: May 30, June 5, and 12, 2008

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The physician's orders dated 8/07 directed the resident to receive a mechanical soft diet. The nurse's note dated 9/10/07 at 6 PM identified Resident #1 was re-admitted from the hospital with diagnoses of E. Coli, urinary tract infection, diverticulitis, and severe dehydration. The hospital physician progress note dated 9/6/07 noted the speech pathologist had conducted an evaluation and noted that when the patient fed herself thin liquids by a cup or straw, there was impulsive rapid gulping and then coughing after swallowing. She recommended dysphagia pureed foods, and 1:1 assistance. Hospital discharge orders dated 9/10/07 directed the resident be provided an advanced dysphagia diet and 1:1 assistance with eating. The Nursing Re-admission Assessment dated 9/10/07 identified the resident had an order for speech therapy. The re-admission physician orders dated 9/10/07 identified an advanced dysphagia diet. The Nutrition Therapy Review dated 9/5/07 through 11/26/07 failed to provide a re-admission assessment by the dietician. The Speech Therapy notes after 11/21/06 failed to identify the resident was re-assessed. The Reportable Incident Event dated 2/7/08 identified that on 2/5/07 Resident #1 choked on a bite-size piece of french toast during breakfast which resulted in death. Interview and review of the clinical record on 6/5/08 at 12:55 PM with the Registered Dietician identified he did not review the record when the resident was re-admitted from the hospital and in a progress note dated 11/26/07, he identified the change in diet. Interview and review of the clinical record on 6/5/08 at 10:50 AM with the Speech Pathologist identified she had not re-evaluated Resident #2 following re-admission. Interview and review of the clinical record on 6/5/08 at 3:30 PM with the Corporate Float Director of Nursing and the Administrator at 3:45 PM identified that when a resident is readmitted with a new dietary order, the dietician or speech therapist should conduct a re-assessment/evaluation related to the new diet.

EXHIBIT B

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION

IN RE: Courtland Gardens Health Center, Inc
53 Courtland Avenue
Stamford, CT 06902

CONSENT ORDER

WHEREAS, Courtland Gardens Health Center, Inc. (hereinafter the "Licensee"), has been issued License No. 1084 C to operate a Chronic and Convalescent Nursing Home known as Courtland Gardens Health Center, (hereinafter the "Facility") under Connecticut General Statutes Section 19a-490 by the Department of Public Health, State of Connecticut (hereinafter the "Department"); and

WHEREAS, the Facility Licensing and Investigations Section (hereinafter "FLIS") of the Department conducted unannounced inspections on various dates commencing on September 10, 2007 and concluding on September 24, 2007; and

WHEREAS, the Department, during the course of the aforementioned inspections identified violations of the Connecticut General Statutes and/or Regulations of Connecticut State Agencies in a violation letter dated November 6, 2007 (Exhibit A – copy attached); and

WHEREAS, an office conference regarding the November 6, 2007 violation letter was held between the Department and the Licensee on December 3, 2007; and

WHEREAS, the Licensee is willing to enter into this Consent Order and agrees to the conditions set forth herein.

NOW THEREFORE, the FLIS of the Department acting herein and through Joan Leavitt its Section Chief, and the Licensee, acting herein and through Lane M. Bowen, its President, hereby stipulate and agree as follows:

1. The Licensee shall execute a contract with an Independent Nurse Consultant (INC) approved by the Department within two (2) weeks of the effective date of this Consent

Order. The INC's duties shall be performed by a single individual unless otherwise approved by the Department. The Licensee shall incur the cost of the INC.

2. The INC shall function in accordance with the FLIS's INC Guidelines (Exhibit B - copy attached). The INC shall be a registered nurse who holds a current and unrestricted license in Connecticut. The Registered Nurse assuming the functions of the INC shall not be included in meeting the nurse staffing requirements of the Regulations of Connecticut State Agencies.
3. The INC shall provide consulting services for a minimum of six (6) months at the Facility unless the Department identifies through inspections that a longer time period is necessary to ensure substantial compliance with applicable federal and state statutes and regulations. The INC shall be at the Facility forty (40) hours per week and arrange his/her schedule in order to be present at the Facility at various times on all three shifts including holidays and weekends. The Department will evaluate the hours of the INC at the end of the six (6) month period and may, in its discretion, reduce or increase the hours of the INC and/or responsibilities, if the Department determines the reduction or increase is warranted. The terms of the contract executed with the INC shall include all pertinent provisions contained in this Consent Order.
4. The INC shall have a fiduciary responsibility to the Department.
5. The INC shall conduct and submit to the Department an initial assessment of the Licensee's regulatory compliance and identify areas requiring remediation within two (2) weeks after the execution of this document.
6. The INC shall confer with the Licensee's Administrator, Director of Nursing Services, Medical Director and other staff determined by the INC to be necessary to the assessment of nursing services and the Licensee's compliance with federal and state statutes and regulations.
7. The INC shall make recommendations to the Administrator, Director of Nursing Services and Medical Director for improvement in the delivery of direct patient care in the Facility.
8. The INC shall submit weekly written reports to the Department documenting:
   a. The INC's assessment of the care and services provided to patients;
   b. The Licensee's compliance with applicable federal and state statutes and regulations; and
   c. Any recommendations made by the INC.

9. Copies of all INC reports shall be simultaneously provided to the Director of Nurses, Administrator, Medical Director and the Department.
10. The INC shall have the responsibility for:
    a. Assessing, monitoring, and evaluating the delivery of direct patient care with particular emphasis and focus on the delivery of nursing services by registered nurses, licensed practical nurses, nurse aides, and orderlies and implementing prompt training and/or remediation in any area in which a staff member demonstrated a deficit. Records of said training and/or remediation shall be maintained by the Licensee for review by the Department;
    b. Assessing, monitoring, and evaluating the coordination of patient care and services delivered by the various health care professionals providing services within the Facility;
    c. Notification to the Department should the INC identify that patients have experienced a significant decline and/or change in condition due to the failure of Facility staff to provide adequate care and services;
    d. Observation of direct care and supervisory staff and their ability to function in said positions. Said evaluations shall be provided to the Licensee with applicable recommendations;
    e. Recommending to the Department an increase in the INC's contract hours if the INC is unable to fulfill the responsibilities within the stipulated hours per week; and
    f. Monitoring the continued implementation of the Licensee's plan of correction submitted in response to the violation letter dated November 6, 2007 (Exhibit A).
11. The Licensee shall contract at its own expense, with a registered nurse credentialed in wound care and infection control and acceptable to the Department to serve as a Wound/Infection Control Consultant (W/ICC) within two (2) weeks of signing this Consent Order, for a minimum of twenty (20) hours per week for six (6) months. The terms of the contract executed with the W/ICC shall include applicable issues related to infection control and wound issues contained in the violation letter dated November 6, 2007.
12. The W/ICC shall evaluate the Facility's infection control program. At the end of the six (6) month period, the Licensee shall no longer be obligated to contract with the W/ICC unless the Department identifies through inspections and/or the W/ICC reports identify

that the continued presence of the Independent W/ICC is necessary to ensure substantial compliance with the provisions of the Regulations of the Connecticut State Agencies and Federal Conditions of Participation for Nursing Homes. The Department may, in its discretion, at any time or from time to time, reduce or increase the W/ICC'S responsibilities and hours.

13. The W/ICC shall conduct and submit to the Department an initial assessment of all patient pressure ulcers and an assessment of the Facility's regulatory compliance with regards to assessments for prevention and care of pressure ulcers and the Facility's infection control program and identify areas requiring remediation. The W/ICC shall submit a weekly written report identifying the Facility's initiatives to comply with applicable federal and state laws and regulations and shall evaluate the overall functioning of the infection control program and wound care program and make subsequent recommendations and the Facility's response to implementation of said recommendations. Copies of said report shall be provided to the Licensee, the Medical Director and the Department.
14. The W/ICC shall perform the following duties:
    a. Evaluation of the Facility's Infection Control Program;
    b. Evaluation of in-service, education and ongoing evaluation of all licensed nursing (inclusive of Agency staff) and nurse aides relevant to infection control practices assessment and care planning for individuals at risk or patients with pressure sores;
    c. Evaluation of the Facility's Infection Control Nurse's ability to implement, monitor and to maintain an effective Infection Control Program;
    d. Review and evaluate the Facility's infection control policies/procedures pursuant to infection control practices;
    e. Evaluation of the Facility's wound care program;
    f. Oversight of education and remediation relevant to assessment of the care provided as it relates to the prevention and care of pressure ulcers;
    g. The Independent W/ICC contracted to oversee wound care shall provide a weekly report to the INC, Licensee, Director of Nurses, Medical Director and the Department regarding his/her responsibilities and an assessment of the Facility's progress as related to issues of skin integrity and infection control;
    h. The Independent W/ICC shall act and perform the duties assigned herein at all times to serve the interest of the Department in assuring the safety, welfare and well-being

of the patients and to secure compliance with applicable federal and state laws and regulations; and

i. The W/ICC shall confer with the Licensee's Administrator, Director of Nursing Services, the INC, Medical Director and other staff determined necessary to the performance of the designated responsibilities set forth herein.

15. The INC and W/ICC shall recommend remediation and/or dismissal of staff to the Licensee's Administrator should it be determined that staff are not performing adequately after extensive remediation efforts.

16. Effective immediately upon execution of the Consent Order, the Licensee shall employ a full time Infection Control Nurse (ICN) whose sole responsibility is to implement an infection prevention, surveillance and control program which shall have as its purpose the protection of patients. The Registered Nurse hired for this position shall have expertise and experience specific to infection control. The ICN shall also be responsible for staff education in the area of infection control and wound care. The Director of Nurses, Medical Director and Administrator shall implement mechanisms to ensure that each patient with an infection is properly identified and receives the appropriate care and services pertinent to the identified infection. The ICN shall ensure the following:

a. Maintenance of an effective infection control program;

b. Review of the facility's policies/procedures pursuant to infection control prevention, with the Director of Nurses, Medical Director and Administrator and revise as necessary;

c. In-servicing of staff pursuant to infection control principles and practices;

d. Evaluation of patients on admission to determine the existence of an infection;

e. Development of policies and procedures relative to assessing for appropriate room, roommate and isolation protocols;

f. Ensure accurate line listings of patient infections to include date of onset of infection, type of infection, site of infection, treatment, room location and any culture/lab results; and

g. Evaluation of staff on a routine basis, on all three shifts, regarding the implementation of infection control techniques; and

h. Implementation of skin assessments, monitoring, tracking and prevention of pressure sores.

17. The INC, the W/ICC, the Administrator, and the Director of Nursing Services shall meet with the Department every four (4) weeks for the first three (3) months after the effective date of this Consent Order and thereafter at eight (8) week intervals throughout the tenure of the INC. The meetings shall include discussions of issues related to the care and services provided by the Licensee and the Licensee's compliance with applicable federal and state laws and regulations.
18. Any records maintained in accordance with any state or federal law or regulation or as required by this Consent Order shall be made available to the INC and the Department, upon request.
19. The Department shall retain the authority to extend the period the W/ICC functions are required, should the Department determine that the Licensee is not able to maintain substantial compliance with federal and state laws and regulations. Determination of substantial compliance with federal and state laws and regulations will be based upon findings generated as the result of onsite inspections conducted by the Department.
20. Effective upon the execution of this Consent Order, the Licensee, through its Governing Body, Administrator and Director of Nursing Services, shall ensure substantial compliance with the following:
    a. Sufficient nursing personnel are available to meet the needs of the patients;
    b. Patient treatments, therapies and medications are administered as prescribed by the physician and in accordance with each patient's comprehensive care plan;
    c. Patient assessments are performed in a timely manner, documented and accurately reflect the condition of the patient;
    d. Each patient care plan is reviewed and revised to reflect the individual patient's problems, needs and goals, based upon the patient assessment and in accordance with applicable federal and state laws and regulations;
    e. Nurse aide assignments accurately reflect patient needs;
    f. Each patient's nutritional and hydration needs are assessed and monitored in accordance with his/her individual needs and plan of care;
    g. The personal physician or covering physician is notified in a timely manner of any significant changes in patient condition including, but not limited to, decline in skin integrity, presence of any infection, and deterioration of mental, physical,

nutritional, and/or hydration status. In the event that the personal physician does not adequately respond to the patient's needs or if the patient requires immediate care, the Medical Director is notified;

h. Patient's with pressure sores and/or impaired skin integrity are provided with the necessary care to treat and prevent pressure sores and/or impaired skin integrity. Wounds, including pressure sores, are monitored and assessed in accordance with current regulations and standards of practice;

i. Necessary supervision and assistive devices are provided to prevent accidents.

21. Appointment of a free floating Nurse Supervisor on each shift whose primary responsibility is the assessment of residents and the care provided by nursing staff. Nurse Supervisors shall maintain a record of any resident related issues(s) or problems(s) identified on his or her shift and a notation as to the subsequent action taken to resolve the problem(s). Said records shall be made available to the Department upon request and shall be retained for a three (3) year period. Nurse Supervisors shall be provided with the following:

a. A job description which clearly identifies the supervisor's day-to-day duties and responsibilities;

b. A training program which clearly delineates each Nurse Supervisor's responsibilities and duties with respect to patient and staff observations, interventions and staff remediation;

c. Nurse Supervisors shall be supervised and monitored by a representative of the Licensee's Administrative Staff, (e.g. Director of Nursing Service or Assistant Director of Nursing Service) to ensure the Nurse Supervisors are functioning in accordance with this Consent Order and state and federal requirements. Said administrative supervising and oversight shall be provided on all three (3) shifts. Records of such administrative visits and supervision shall be retained for the Department's review; and

d. Nurse Supervisors shall be responsible for ensuring that care is provided to patients by caregivers is in accordance with individual comprehensive care plans.

22. Individuals appointed as Nurse Supervisor shall be employed by the facility, shall not carry a patient assignment and shall have previous experience in a supervisory role.

23. The Licensee shall maintain minimum staffing ratios of eight (8) patients to one (1) nurse aide between the hours of 7:00 AM to 3:00 PM; twelve (12) patients to one (1)

nurse aide between the hours of 3:00 PM to 11:00 PM and twenty (20) patients to one (1) nurse aide between the hours of 11:00 PM to 7:00 AM.

24. The Licensee, within seven (7) days of the execution of this document, shall designate an individual within the Facility to monitor the requirements of this Consent Order. The name of the designated individual shall be provided to the Department within said timeframe.

25. The Licensee shall establish a Quality Assurance Program (QAP) to review patient care issues including those identified in the November 6, 2007 violation letter. The members of the QAP shall meet at least monthly to review and address the quality of care provided to patients and, if applicable, implement remediation measures. Membership shall at a minimum, include the Administrator, Director of Nurses, Infection Control Nurse, Nurse Supervisors, and the Medical Director. Minutes of the QAP meetings shall be kept for a minimum of three (3) years and made available for review upon request of the Department.

26. The Licensee shall pay a monetary penalty to the Department in the amount of six thousand dollars ($6,000.00), by money order or bank check payable to the Treasurer of the State of Connecticut and mailed to the Department within (2) weeks of the effective date of this Consent Order. The money penalty and any reports required by this document shall be directed to:

Rosella Crowley, R.N.
Supervising Nurse Consultant
Facility Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, P.O. Box 340308 MS #12HSR
Hartford, CT 06134-0308

27. All parties agree that this Consent Order is an Order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department's available legal remedies against the Licensee for violations of the Consent Order or of any other statutory or regulatory requirements, which may be sought in lieu of or in addition to the methods of relief listed above, including all options for the issuance of citations, the imposition of civil penalties calculated and assessed in accordance with Section 19a-524 et seq. of the General Statutes, or any other administrative and judicial relief provided by law. This Consent Order may be admitted by the Department as evidence in any proceeding between the

Department and the Licensee in which compliance with its terms is at issue. The Licensee retains all of its rights under applicable law.

28. The execution of this document has no bearing on any criminal liability without the written consent of the Director of the MFCU or the Bureau Chief of the Department of Criminal Justice's Statewide Prosecution Bureau.
29. The terms of this Consent Order shall remain in effect for a period of two (2) years from the effective date of this document unless otherwise specified in this document.
30. The Licensee understands that this Consent Order and the terms set forth herein are not subject to reconsideration, collateral attack or judicial review under any form or in any forum including any right to review under the Uniform Administrative Procedure Act, Chapter 368a of the Statutes, Regulations that exists at the time the agreement is executed or may become available in the future, provided that this stipulation shall not deprive the Licensee of any other rights that it may have under the laws of the State of Connecticut or of the United States.
31. The Licensee had the opportunity to consult with an attorney prior to the execution of this Consent Order.

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WITNESS WHEREOF, the parties hereto have caused this Consent Order to be executed by their respective officers and officials, which Consent Order is to be effective as of the later of the two dates noted below.

COURTLAND GARDENS HEALTH CENTER - LICENSEE

2-5-08
Date

By: Lane Bowen
Lane M. Bowen, President

STATE OF Kentucky)

County of Jefferson) ss February 5 2007

Personally appeared the above named Lane M. Bowen and made oath to the truth of the statements contained herein.

My Commission Expires: 2/16/2012
(If Notary Public)

Jenny McGarry
Notary Public [ ]
Justice of the Peace [ ]
Town Clerk [ ]
Commissioner of the Superior Court [ ]

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

2/7/08
Date

By: Joan D. Leavitt
Joan D. Leavitt, R.N., M.S., Section Chief
Facility Licensing and Investigations Section

RECEIVED 2008 FEB -6 D

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT A
PAGE 1 OF 25

November 6, 2007

Mr. John Halloran, Administrator
Courtland Gardens Health Center
53 Courtland Ave
Stamford, CT 06902

Dear Mr. Halloran:

Unannounced visits were made to Courtland Gardens Health Center on September 10, 11, 12, 19, 20, and 24, 2007 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations, and licensing and certification inspections.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits.

An office conference has been scheduled for November 19, 2007 at 10 AM in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish legal representation, please feel free to have an attorney accompany you to this meeting.

Please prepare a written Plan of Correction for the above mentioned violations to be presented at this conference.

Each violation must be addressed with a prospective Plan of Correction which includes the following components:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).
2. Date corrective measure will be effected.
3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Rosella Crowley RN (BSC)

Rosella Crowley, R.N.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

RAC:bh

c. Director of Nurses
Medical Dirctor
President
Complaints #6679, 6744

Phone: (860) 509-7400
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12HSR
P.O. Box 340308 Hartford, CT 06134
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EXHIBIT A
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THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2)(L) and/or (k) Nurse Supervision (1).

1. Based on clinical record reviews, observations, and interviews for three of fifteen sampled residents with a change in condition (R# 15, 22, 25), the facility failed to ensure that the responsible party was notified of a need for a diet downgrade from thin liquids to nectar thick liquids, and/or puree, and/or antibiotic therapy, and/or failed to notify the resident ' s attending physician and/or obtain a treatment order for a new pressure sore. The findings include:
    a. Resident #25 ' s diagnoses included Alzheimer's disease, anemia, anxiety disorder, and optic atrophy. The annual assessment dated 7/20/07 identified that the resident was moderately cognitively impaired, was totally dependent on staff assistance for all ADL ' s including eating. Physician orders dated 7/19/07 directed the resident ' s liquids be thickened to nectar thick. Physician orders dated 7/25/07 directed the resident receive a puree diet. Nurse ' s notes dated 7/25/07 at 7:00 PM noted that the responsible party was made aware that the resident required a puree diet. The twenty-four hour nursing reports dated from 7/19/07 to 7/30/07 failed to document that the family had been informed of the resident's need for nectar thick liquids. Interview and review of the clinical record on 9/12/07 at 9:00 AM with the MDS coordinator failed to provide evidence that the family had been informed of the need for nectar thick liquids. Interview with the responsible party on 9/10/07 at 1:40 PM noted that they had not been informed in July of the resident's need for thickened fluids.
    b. Resident #22's diagnoses included urinary tract infection, urosepsis, dementia and legal blindness. A quarterly assessment dated 07/13/07 identified the resident was cognitively impaired, totally dependent on staff for all activities of daily living (ADL) including bed mobility, incontinent of bowel and bladder, and had intact skin integrity. The resident care plan (RCP) dated 07/24/07 identified the need for a mechanical lift transfer, and the potential for alteration in skin integrity secondary to fragile skin. Interventions included handling the resident gently during transfers, and to turn and reposition every two hours and as needed. A re-admission nursing assessment dated 09/07/07 identified a cut on the resident's right great toe, a skin tear on the left shin, and a bruise on the left forearm. Observation of incontinent care on 09/10/07 at 1:44 PM noted the presence of an open area on the coccyx. The surveyor inquired about the open area on the coccyx at that time, and the NA replied, " I ' ll tell the nurse ". The resident's visible peri-areas and buttocks were reddened with deep lines of imbedded demarcation on the buttocks. Subsequent to surveyor inquiry, an assessment of the resident's coccyx area by the DNS and (APRN) on 9/11/07 identified a pressure ulcer located on the coccyx that measured 2.0 CM X 0.5 CM. An interview and review of the resident's clinical record with the Director of Nursing (DNS) on 09/11/07 at 2:30 PM failed to provide evidence that the physician had been notified and/or a treatment obtained for the open area on the coccyx when it was first identified on 9/10/07. During an interview with the unit charge nurse on 09/12/07 at 7:22 AM, she indicated that she could not recall whether she had been

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informed of the resident's change in skin condition.

c. Resident #15's diagnoses included end stage renal failure requiring hemodialysis, depression, and hypertension. Nurses' notes dated 12/11/06 identified that based on results of a modified barium swallow done on 12/7/06, the resident required a pureed diet. Review of the clinical record and 24 hour reports failed to provide evidence that the family had been notified of the change in diet. Nurse's notes dated 2/28/07 identified that the resident returned from dialysis with orders for Keflex for 10 days (for a possible infection of the dialysis fistula site) which was changed on 3/1/07 to Levaquin. Review of the clinical record and 24 hour reports failed to provide evidence that the family had been notified of the need for antibiotic therapy.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administration(3)(D).

2. Based on interviews with family members, residents and staff, and a review of grievance logs, the facility failed to provide evidence that they responded to the concerns of family members or residents. The findings include:

   a. Multiple interviews with the families of Residents # 's 22 and 33 throughout the survey noted they had both repeatedly brought issues regarding the quality of care to the attention of the former DNS and/or former administrator without having the problems resolved. Interview and review of the grievance log with the corporate nurse on 9/19/07 failed to provide evidence that the family grievances had been logged in, investigated, and/or responses provided.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (o) Medical Records (2)(H) and/or Connecticut General Statutes19a-550.

3. Based on clinical record reviews, observations and interviews for two of six sampled residents who utilized restraints (R#7, 26), the facility failed to ensure that resident assessments were completed by the interdisciplinary team prior to initiating restraints, that alternatives to restraints were attempted/documented, and/or that attempts at reduction had taken place, and/or that the least restrictive device necessary to treat a medical symptom was in place/documented. The findings include:

   a. Resident #7's diagnoses included Alzheimer's disease and a distal radius fracture. A quarterly assessment dated 1/6/07 identified the resident was without cognitive impairment, and totally dependent on staff for all ADL's. A physician progress note dated 3/1/07 identified that the resident was confused and had experienced a fall in the dining room resulting in a left wrist fracture and that a waist restraint had been applied. Observations of the resident on 9/10/07 and 9/11/07 noted the resident seated in a wheelchair with a seatbelt restraint in place. Interview and review of the clinical record

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on 9/11/07 at 2 PM with a clinical nurse failed to provide evidence that alternatives to restraints had been attempted prior to placing the seatbelt on the resident, and/or that attempts to reduce the restraint use had been initiated since applying it on 3/1/07.

b. Resident #26 was admitted to facility on 08/27/07 with diagnosis that included dementia. An initial assessment dated 08/31/07 identified that the resident was moderately cognitively impaired, required extensive assistance with activities of daily living, displayed physically abusive, socially inappropriate and resistive to care behaviors, and utilized a trunk restraint daily. The resident care plan (RCP) dated 08/30/07 identified the potential for accidental injury secondary to use of a restraint (" seatbelt in wheel chair "). Interventions included discussing in restraint committee the need for restraint versus appropriate options. Nurse's notes from 08/2707 at 8:00 P.M. through 08/28/07 during the 3-11 P.M. shift noted alarms being utilized for safety, that the resident was continuously getting up, and that the resident required staff to continuously redirect to remain seated. Nurse ' s notes dated 08/29/07 for the 7-3 P.M. shift noted that the resident was continuously attempting to get up from the wheel chair/at risk for falls. The APRN ordered a seat belt for safety. Observation of the resident on 09/12/07 at 2:09 P.M. with the Assistant Director of Nursing (ADON) identified the resident with a " weaving through buckle type strap " seat belt. Further observation noted that the resident was unable to release the restraint when prompted to do so by the ADNS. Interview and review of the resident ' s clinical record with the ADON on 09/12/07 failed to provide evidence that the type of seatbelt utilized was the least restrictive device necessary to treat a medical symptom, and/or that the restraint was not for the purpose of staff convenience.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administration (3)(D) and/or Connecticut General Statutes19a-550.

4. Based on clinical record review, observation and interview for the only sampled resident at risk for skin breakdown, totally dependent on staff for all mobility and with contractures of the extremities (R#3), the facility failed to prevent neglect of the resident as evidenced by the failure to ensure necessary care and services were provided, including treatment of the contractures and/or prevention of pressure sores, to prevent the resident ' s lower extremities from severe pressure sores resulting in osteomyelitis. The findings include:

   a. Resident #3's diagnoses included dementia, depression, and tube feeding. A quarterly assessment dated 2/23/07 identified that the resident was cognitively impaired, totally dependent on staff for all Activities of Daily Living (ADL's), and had no pressure sores. The care plan dated 2/27/07 identified the potential for altered skin integrity. Interventions included keeping pressure off the heels in bed. The care plan dated 4/23/07 identified a stage two pressure sore of the left 5th toe. Interventions included keeping the pressure off the heels in bed as needed (PRN).

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Nurse ' s notes dated 4/23/07 identified that the resident ' s left foot, fifth toe was found to have an opened old scab measuring 1.2cm x 1.2 cm with a small amount of blood and an open area in between the fourth and fifth toe. Physician orders dated 4/26/07 directed a treatment to the left 5th toe.

Nurse's notes dated 5/21/07 noted a new open area of the left foot hallux. Physician orders dated 5/21/07 directed a treatment to the left hallux. On 6/6/07, physician orders directed the application of bacitracin to the left hallux, left 5th toe, and between the left 4th and 5th toes, and to keep feet pressure free. A nurse's note dated 6/15/07 noted the treatment to the left foot was changed to Bactroban and that heelbo's should be worn at all times. The care plan dated 7/31/07 noted a problem with positioning related to the resident pulling up the legs and feet under the buttocks (causing pressure on the foot). Interventions included repositioning to prevent skin to skin contact, and to obtain an occupational therapy (OT) screen for positioning in bed and the wheelchair. Wound assessment documentation noted that on 7/2/07, the left lateral foot was a stage III that measured 2.2 by 1.4 by 0.1. On 9/7/07, the wound had declined to a 7.5 by 2.9 stage III. Observations of the wound on 9/11/07 at 2:16 PM noted the left lateral foot with an approximately 8 cm long open area with muscle and tendon visible at the top and soft tissue along the base. Interview on 9/13/07 at 12:34 PM with the Wound Nurse noted that muscle and tendon exposed are considered a stage IV pressure sore not a stage III. Interview and review of the clinical record, nurse's notes, treatment records, and physician orders with the Charge Nurse on 9/11/07 at 1 PM failed to provide documented evidence that foot protective devices had been implemented prior to 6/06/07. The Charge Nurse identified that the resident would pull the left leg/foot up behind the right calf causing the (outside of the left foot) to be flat on the bed. Further review, failed to provide evidence that the occupational therapist and/or physical therapist had assessed the resident ' s contracture of the leg or implemented any devices (i.e. splints) to prevent further breakdown of the resident ' s contracted foot. Subsequent to surveyor inquiry, the occupational therapist was to assess the resident for positioning/pressure relief needs. An x-ray report dated 7/31/07 noted that the left foot wounds were suspected of having osteomyelitis. Interview with the resident's physician on 9/12/07 at 3:40 PM noted that he suspected the wound occurred from the resident rubbing the feet on the bed and/or skin and subsequently developed osteomyelitis.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administration (3)(A) and/or (g) Reportable Events (6).

5. Based on clinical record reviews, observations and interviews for three of seven sampled residents with skin tears/injuries (R#12, 15, 22), the facility failed to ensure that investigations into the origin of the injuries had been conducted. The findings include:
   a. Resident #12 ' s diagnoses included status post total right hip replacement. An

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admission assessment dated 6/29/07 identified that the resident required extensive assistance from two persons for bed mobility, and transfer, and had abrasions and bruises present. The care plan dated 7/26/07 identified a new skin tear to the left elbow. Review of facility documentation on 9/11/07 at 2:30PM with the Corporate Nurse failed to provide documented evidence that an investigation had been initiated into the origin of the skin tear on 7/26/07.

b. Resident # 22 ' s diagnoses included dementia and legally blind. An admission assessment dated 04/18/07 identified the resident was cognitively impaired and totally dependent on staff for all activities of daily living. Physician orders dated 04/11/07, 04/12/07 and 06/14/07 directed the application of geri-sleeves (protective sleeves) to both upper and lower extremities secondary to fragile skin. Review of physician orders and/or nurse ' s notes identified that the resident on 04/14/07 sustained an abrasion on the right cheek and chin, on 04/26/07 sustained a skin tear to right lateral leg, on 07/08/07 sustained a skin tear to right lower leg and on 08/09/07 was found with open areas on the feet. During an interview and review of facility documentation with the corporate nurse on 09/20/07 at 11:45 A.M., identified that she was unable to provide documented evidence that investigations into the origin of the injuries had been conducted.

c. Resident #15 ' s diagnoses included end stage renal failure requiring hemodialysis, depression, and hypertension. Physician orders dated 1/8/07 directed an x-ray of the lower mid back, and a personal alarm in the wheelchair and bed. Nurse ' s notes dated 1/8/07 at 5 PM identified that the dialysis center called to inform the facility that the resident had a discoloration of the left lower back, that was swollen and was tender to touch. The resident informed the dialysis center and later the facility, that she had fallen at the facility and someone, helped her up. The note identified that the resident complained of pain in the area and that an x-ray would be done in the morning. X-ray results obtained on 1/11/07 identified a marked compression fracture of T12. Interview and review of the facility investigation/report with the DNS on 9/12/07 at 11AM failed to provide evidence that an investigation into the resident ' s injury had been conducted and/or that staff were interviewed to determine who picked the resident up off the floor without having a nurse assess the resident.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administration (3).

6. Based on observations, the facility failed to maintain the facility in a clean, neat, orderly, homelike and/or sanitary manner. The findings include:
   a. A tour of the facility on 09/10/07 with the maintenance supervisor identified the following:
      i. Resident bedroom walls were damaged and marred.
      ii. Wall paper was damaged and peeling off.
      iii. Wall paper had been painted over and was noted to be peeling and/or with

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visible old patch repairs.

iv. Ceiling tiles through out the facility were damaged, stained, painted and/or bleeding through stains.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervision (1).

7. Based on clinical record review and interview for the only sampled resident on hemodialysis (R#15), the facility failed to ensure that the resident was assessed when changes in condition were identified. The findings include:

   a. Resident #15's diagnoses included end stage renal failure requiring hemodialysis, depression, and hypertension. Nurse ' s notes dated 4/10/07 noted the physician was notified and approved of increasing the resident ' s nutritional supplement to three times a day from twice. The next nursing note was dated 4/14/07 and identified a fair appetite and oxygen in use at 2 liters. There were no further nursing notes/assessments until 4/27/07 at 6 AM when the resident was noted to have a puffy face and an orange sized raised area on the inner thigh. The physician was notified and directed that the dialysis center evaluate the resident while he/she was there. The resident was also noted to have difficulty swallowing medications and liquids. The resident went to dialysis and returned. The record lacked any communication of an assessment at the dialysis center regarding the resident's symptoms. An evening shift note on 4/27/07 failed to document an assessment of the resident's facial swelling, difficulty swallowing, or any respiratory assessments except oxygen saturations. The record lacked a nursing note for the 11 PM - 7 AM shift 4/28/07. On 4/28/07 at 11 AM, notes document that the physician was notified of generalized pain complaints. The resident had diminished breath sounds and crackles at the bases. A chest x-ray was ordered. The resident then complained of abdominal pain and had tenderness on palpation. The physician was again called and ordered the resident transferred to the hospital at 10:25 AM. Interview and review of the clinical record and 24 hour reports with the corporate nurse on 9/12/07 at 1 PM failed to provide evidence that assessments of the resident had been completed and/or documented from 4/14-4/27/07 (including post-dialysis assessments), and/or subsequent to the resident ' s return from dialysis on 4/27/07 when the resident had a change in condition. According to Clinical Nursing Skills, Fifth Edition, 2000, if any unusual findings are assessed, complete a more in depth assessment of the particular system affected. Throughout the day, continue to assess changes in the client's condition by paying particular attention to the alterations from normal that you identified in the original assessment. At the end of the shift, make a notation of any changes in the client's condition.

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The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (m) Nursing Staff (2)(A).

8. Based on clinical record review and observation for one of twenty-four sampled residents (R#26), the facility failed to ensure that care plan interventions related to the releasing of restraints were initiated. The findings include:
    a. Resident #26 was admitted to facility on 08/27/07 with diagnosis that included dementia. An initial assessment dated 08/31/07 identified that the resident was moderately cognitively impaired, required extensive assistance with activities of daily living, displayed physically abusive, socially inappropriate and resistive to care behaviors, and utilized a trunk restraint daily. The resident care plan (RCP) dated 08/30/07 identified the potential for accidental injury secondary to use of a restraint (" seatbelt in wheel chair "). Interventions included releasing the restraint during meals and activities. Observation of the resident on 09/10 and 9//11/07 at 2:09 P.M. with the Assistant Director of Nursing (ADON) identified the resident was unable to release the restraint when prompted to do so by the ADNS, and that the restraint was not released during the noon meals on either day.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervision (1) and/or (m) Nursing Staff (2)(A).

9. Based on clinical record reviews, reviews of twenty-four hour reports, and interviews for two sampled residents (R#1, 15), the facility failed to ensure that physician orders for laboratory testing and/or x-rays were carried out. The findings include:
    a. Resident #1 ' s diagnoses included diabetes, morbid obesity, renal failure and low albumin. Physician orders dated 12/7/06 directed laboratory testing for 12/12/06 of liver function tests and a valproic acid level. Physician orders dated 2/15/07 directed multiple laboratory blood tests, including CBC, thyroid studies, metabolic panel, lipid panel and hemoglobin AIC. Physician orders dated 4/12/07 noted as follows; " please do hgbAIC, BMP, and albumin every 3 months. (see my 11/7/06 orders) - last done 11/8/06. (Next draw tomorrow 4/13) ". Also ordered for 4/13/07 and every 6 months were valproic acid levels and carbamazepine levels that should have been drawn in February 2007. Interview and review of the clinical record with the corporate consultant on 9/11/07 at 1 PM failed to provide evidence that the physician orders for lab work were carried out in December 2006, February 2007, April 2007, or July 2007. No lab work was available on the chart for review, and when the consultant called the lab for copies of reports, they had no record of any testing being done.
    b. Resident #15 ' s diagnoses included end stage renal failure requiring hemodialysis, depression, and hypertension. Physician orders dated 1/8/07 directed an x-ray of the lower mid back, and a personal alarm in the wheelchair and bed. Nurse ' s notes dated 1/8/07 at 5 PM identified that the dialysis center called to inform the facility that the

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resident had a discoloration of the left lower back, that was swollen and was tender to touch. The resident informed the dialysis center that she had fallen at the facility and someone helped her up. The note identified that the resident complained of pain in the area and that an x-ray would be done in the morning. Nurse ' s notes for 1/9/07 failed to reflect that the x-ray had been done. Nurse ' s notes dated 1/10/07 by the DNS noted that the x-ray company was called and a message left regarding the x-ray not being done. The x-ray was done on 1/10/07 at 9:40 AM, but no results were available per nurse ' s notes on 1/10/07 at 10:50 PM. On 1/11/07 at 11:20 AM, the x-ray report was received and determined that the resident had a marked compression fracture of T12. Interview and review of the clinical record with the DNS on 9/12/07 at 11AM failed to provide evidence that the x-ray of the resident's back had been completed.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (m)Nursing Staff (2)(A) and or (m) Nursing Staff (2)(B).

10. Based on clinical record reviews, observations, review of facility policies and procedures for pressure sore treatment and prevention, and interviews for 11 of 14 sampled residents (Residents #3, 10, 12, 18, 29, 30, 31, 21, 23, 11, and 22), the facility failed to provide necessary care and services for prevention and/or treatment of pressure sores. The findings include:

    a. Resident #3's diagnoses included dementia, depression, and tube feeding. A quarterly assessment dated 2/23/07 identified that the resident was cognitively impaired, was totally dependent on staff for Activities of Daily Living (ADL's), and had no pressure sores. The care plan dated 2/27/07 identified the potential for altered skin integrity. Interventions included to keep pressure off the heels in bed. The care plan dated 4/23/07 identified a stage two pressure sore of the left 5th toe. Interventions included keeping the pressure off the heels in bed as needed (PRN).Physician orders dated 4/26/07 directed a treatment to the left 5th toe. Nurse's notes dated 5/21/07 noted a new open area of the left foot hallux. Physician orders dated 5/21/07 directed a treatment to the left hallux. On 6/7/07, physician orders directed the application of bacitracin to the left hallux, left 5th toe, and between the left 4th and 5th toes, and to keep pressure off the feet. A nurse's note dated 6/15/07 noted the treatment to the left foot was changed to Bactroban and that heelbo's should be worn at all times. The care plan dated 7/31/07 noted a problem with positioning related to the resident pulling up the legs and feet under the buttocks. Interventions included repositioning to prevent skin-to-skin contact and to obtain an occupational therapy (OT) screen for positioning in bed and the wheelchair. Interview with the Director of Rehabilitation on 9/11/07 at 12:12 PM noted that they had not received any referrals from nursing related to positioning assistance for Resident #3. Subsequent to surveyor inquiry, an OT screen was completed. The Director of Rehab noted that the resident's lower extremities had declined in range of motion (contractures) from 75% to 50% since January 2007 when last screened. Wound

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assessment documentation noted that on 7/2/07, the left lateral foot was a stage III that measured 2.2 by 1.4 by 0.1. On 9/7/07, the wound had declined to a 7.5 by 2.9 stage III. Observations of the wound on 9/11/07 at 2:16 PM noted the left lateral foot with an approximately 8 cm long open area with muscle and tendon visible at the top and soft tissue along the base. Interview on 9/13/07 at 12:34 PM with the Wound Nurse noted that muscle and tendon exposed are considered a stage IV pressure sore not a stage III. Interview and review of the clinical record, nurse's notes, treatment records, and physician orders with the Charge Nurse on 9/11/07 at 1 PM failed to provide evidence that foot protective devices had been implemented until 6/15/07. The Charge Nurse identified that the resident would pull the left leg/foot up behind the right calf causing the (outside of the left foot) to be flat on the bed. An x-ray report dated 7/31/07 noted that the left foot was suspected of having osteomyelitis of the little toe and distal fifth metatarsal. Interview with the resident's physician on 9/12/07 at 3:40 PM noted that he suspected the wound occurred from the resident rubbing the feet on the bed and/or skin and subsequently developed osteomyelitis.

b. Resident #10's diagnoses included stroke, right arm fracture, and dehydration. An admission nursing assessment dated 9/2/07 identified that the resident was cognitively impaired, totally dependent on staff for all ADL's, and was incontinent of bowel and bladder. Physician orders dated 9/2/07 directed the application of wound gel and a dry clean dressing twice a day. Both the discharge summary/referral from the hospital and the admission nurse's note dated 9/2/07 identified that the sacral area had "multiple open areas and a 3 by 3 cm reddened spot with scant sero-sanguinous drainage." A care plan dated 9/3/07 identified a stage one pressure sore. Interventions included weekly pressure ulcer assessment by the wound care nurse. Observations of wound care on 9/11/07 at 10:20 AM noted the resident had two stage two pressure sores of the sacrum. The sacrum had a large, irregularly shaped red area which measured 10 cm on the sacrum, and 7 cm by 4 cm on the right buttock. Observations of incontinent care on 9/12/07 at 7:45 AM noted a gauze over the sacral wound with feces noted under the gauze. The nurse aide informed the charge nurse and the supervisor came to replace the dressing. Feces were noted upon dressing removal. The sacral area had increased redness and inflammation from the observations on 9/11/07. Two new open areas were noted on the lower left buttock and the left upper buttock had a large 14 by 14 cm reddened area. Interview with the charge nurse and supervisor and review of the clinical record following the wound care observations failed to provide evidence that the sacral area had been assessed from 9/2 through 9/11/07 and that an assessment had been done and documented when the area enlarged/declined.

c. Resident #12 was admitted to the facility on 6/22/07 with diagnoses that included status post total right hip replacement. An admission assessment dated 6/29/07 identified that the resident was moderately cognitively impaired, required extensive assistance with two persons for bed mobility and transfers, was incontinent of bowel and bladder, and had no pressure ulcers. The Norton Pressure Sore Risk Assessment dated 6/23/07 identified that the resident was at high risk for pressure sore development. The care plan dated 7/5/07

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identified the risk for pressure sore development. Interventions included to assess the skin weekly, provide a pressure redistribution mattress and a chair cushion PRN (as needed), and to change position every two hours. No interventions were identified to promote heel redistribution/pressure reduction and/or to prevent heel/feet pressure sores. A subsequent care plan dated 9/7/07 identified a right heel pressure ulcer. Interventions included to keep pressure off the heels while in bed and to apply heel boots while in bed. Physician orders dated 9/7/07 directed bilateral heel boots to the lower extremities when in bed. A weekly pressure ulcer report dated 9/6/07 identified a new onset, Stage II right heel pressure ulcer measuring 1centimeter (cm) by 1cm. Constant observations on 9/10/07 from 7:15AM until 11:15AM (total of four hours) noted the resident in bed with both heels lying directly on the mattress. The resident's feet and toes were noted to be pressed against the foot board. The right heel was noted to have a dressing in place. The resident was not repositioned off of his/her back for the 4 hours and the heels remained flat on the bed and touching the footboard. Subsequent to surveyor inquiry on 9/10/07 at 11:30 AM, the heels were elevated on pillows. Observation of wound care with the APRN on 9/10/07 at 11:30 AM noted the right heel had a yellow wound center and surrounding maceration. The area measured 1.1 b y 1.2 cm and declined from 75-100% bright red granulation tissue to less than 25% granulation tissue. Also noted at that time was the presence of a new stage one pressure sore of the left heel which was not measured but appeared to be 50 cent size and bright red. Interview and review of the clinical record with the Assistant Director of Nurses (ADNS) on 9/10/07 at 11:45 AM failed to provide evidence that a care plan had been developed and/or interventions initiated to prevent the development of heel pressure sores for a resident status post hip surgery/fracture.

d. Resident #18 was admitted to the facility on 6/13/07 with diagnoses that included paraplegia, transverse myelitis, and recurrent pressure ulcers. The admission nursing assessment dated 6/13/07 identified that the resident's skin was intact, the resident was incontinent of bowel, had a suprapubic tube, and was dependent on staff for all ADL's. The Norton Pressure Sore Risk Assessment dated 6/13/07 identified that the resident was at high risk for pressure sore development. An interim care plan dated 6/15/07 did not identify the resident's risk for pressure sores or any interventions for prevention. On 6/29/07, the Advanced Practice Registered Nurse (APRN) identified that a stage II pressure sore of the right gluteus and coccyx had been present as of 6/21/07. Nurse's notes for 6/21/07 failed to reflect an assessment of the stage II pressure sore. A nurse's note dated 6/29/07 noted that the excoriation to the scrotum and buttock were not improving and the resident was seen by the APRN. The APRN wound note dated 6/29/07 noted a stage II pressure sore of the right gluteus measuring 6 by 5 by 0.5 cm with an excoriation of the coccyx. The treatment was changed to Panafil. The resident was evaluated at the wound care center on 7/19/07. Treatment was changed to a wound vac. Wound assessments dated 7/2/07 identified the area as stage IV and as of 9/7/07 continued to be a stage IV with tunneling and measurements of 5.7 by 4.4 by 4.0 cm. Interview and review of the clinical record with the APRN on 9/13/07 at 9:36 AM noted

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that she had first been made aware of the wound on 6/29/07. Review of the treatment kardexes, physician orders and nursing notes failed to provide evidence that the wound was assessed and/or treated from 6/21-6/29/07. Interview and review of the care plan with the Minimum Data Set (MDS) Coordinators on 9/11/07 at 2:25 PM and 9/12/07 at 3:20 PM failed to provide evidence that a care plan for the prevention of pressure sores and or treatment of bowel incontinence had been developed/initiated. Further review failed to provide evidence that interventions were initiated when the wound declined to a stage IV in July. Interview with management personnel noted that the resident ' s low air loss bed had not been requested/delivered until 8/31/07.

e. Resident #29's diagnoses included depression, schizophrenia, anxiety, and a hernia repair on 8/27/07. The resident was admitted to the facility on 8/14/07 after syncope with a head laceration, and discharged to the hospital for a para-esophageal hernia repair returning on 8/30/07. The initial assessment dated 8/21/07 identified that the resident was cognitively impaired with short term memory problems, required a one person physical assistance for bed mobility, transfer, and ambulation, required extensive assistance for toileting/bathing, had no pressure sores or other skin conditions, and was continent of bowel and bladder. The Norton Scale for pressure ulcer risk dated 8/14/07 identified that the resident was not at risk for pressure sore development. The nursing re-admission assessment dated 8/30/07 identified that the resident's skin was intact. The care plan dated 8/14/07 identified a self-care deficit related to an anxious mood, decreased mobility, and unstable health problems. Specific interventions related to the resident's needs were not identified in the care plan. Physician orders dated 9/1/07 directed the application of Critic Aid to the left buttock "excoriation" every shift. There were no nursing notes or description of the area related to the "excoriation" or wound records were noted from 9/1/07 through 9/7/07. On 9/7/07 the APRN assessed the "excoriation" on the left buttock. The wound was a stage two pressure sore measuring 3 by 1.1 by <0.1 cm that contained 50% slough. A treatment with Panafil and dry dressing daily was ordered as well as repositioning. Constant observations on 9/12/07 noted the resident lying in bed on the back from 6:42 AM through 7:52 AM when a nurse aide accompanied the resident to the bathroom. A pressure sore of the left buttock was visible and was lacking a dressing. The resident started that his/her "bottom was sore." The resident was toileted, returned to bed and was noted to continue lying on his/her back. At 9:40 AM, RN#1 entered the room, gave the resident medications, and stated that she had too many medications to give and would have to do the resident's buttock treatment later. The resident lay back down on his/her back. At 9:07 AM, the nurse aide took the resident into the bathroom and provided morning care while the resident sat on the toilet. The resident repeatedly asked to get up, "I can't sit here anymore." The resident was then seated in the bed side chair without the benefit of a pressure reducing cushion. At 9:41 AM, the Assistant Director of Nursing entered the room and completed the resident's dressing. The resident had a brief on. Upon removal of the brief the buttock area/wound was noted to be purple and/or bright red. The pressure sore measured 2.5 by 1.5 cm and was 0.1 cm deep. At the completion of the dressing change,

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the resident was placed back into the bedside chair, which continued to lack a pressure reducing cushion. Interview and review of the clinical record with the ADNS on 9/12/07 at 3 PM failed to provide evidence that the wound was assessed/documented when first discovered on 9/1/07 and through 9/7/07 when the APRN assessed the area, that any care plan had been developed prior to and/or after the pressure sore developed, that a pressure reducing cushion had been provided to the resident, or that staff were prompting and/or assisting the resident to reposition off of the area. Constant observations from 6:42 AM through 9:41 AM noted the resident positioned on the pressure sore with the exception of toileting twice and placed the chair, which lacked a pressure relieving device.

f. Resident #30 was admitted to the facility on 8/11/07 with diagnoses that included C-Difficile, MRSA in the nares, and a urinary tract infection. An admission assessment dated 8/16/07 identified that the resident required extensive assistance with bed mobility, transfers, personal hygiene/bathing, was totally incontinent of bowel with diarrhea, and had both Stage II and IV pressure ulcers. The initial care plan dated 8/13/07 identified the presence of a pressure ulcer on the left heel. The care plan further identified the problem of incontinence with interventions that included providing incontinent care every two hours. Nursing notes dated 8/28/07 at 1:00PM identified that the resident was incontinent of loose soft stools. On 8/30/07 the APRN wound assessment identified a new Stage II pressure sore of the coccyx which measured 2cm x 0.3cm x <0.1cm and a Stage II left buttock pressure ulcer which measured 1.2cm x 0.4cm x <0.1 cm both with drainage and some slough. Physician orders dated 8/30/07 directed to apply Panafil Ointment to the coccyx and left buttock every day. Constant observations on 9/12/07 from 7:00 AM until 9:50 AM (total of 2 hours and 50 minutes), noted the resident positioned on the back without the benefit of repositioning and assessing for the need for incontinent care. Observation of incontinent care at 10:00 AM noted the resident had been incontinent of a moderate amount of stool. A dressing on the coccyx was noted to be soiled with stool. Observation with the APRN present at 11:59AM noted a stage II pressure ulcer on the coccyx with some slough and excoriation and redness surrounding the wound. A new " V " shaped open area was noted on the coccyx/buttock area. Interview and review of the clinical record with the APRN on 9/12/07 at 11:15AM noted that the resident had a new linear open area on the buttock which was from excoriation and pressure. The left buttock pressure sore was healed but remained reddened. Review of the current care plan on 9/13/07 failed to provide evidence that the resident's coccyx and buttock pressure sores had been addressed and/or that interventions to aid in healing or prevent new pressure sores from developing had been developed.

g. Resident #31's diagnoses included chronic renal insufficiency, and leg ulcers. An admission assessment dated 8/10/07 identified that the resident was without cognitive impairment and totally dependent on staff for all ADL's. The care plan dated 8/6/07 identified a stage two pressure sore of the buttocks. Interventions included weekly assessments by the wound nurse. Physician orders dated 8/2/07 directed the application

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of Baza cream for 14 days. The treatment kardex for August 2007 noted that the Baza was applied from 8/2/07 through 8/15/07. There was no evidence of a treatment to the area until 8/28/07 when the APRN ordered a wound treatment and completed an assessment. Observations on 9/12/07 at 1:20 PM noted a stage two area of the left buttock that was healing. Interview and review of the clinical record with the charge nurse on 9/12/07 at 1:20 PM failed to provide evidence that the wound was assessed from 8/2 through 8/28 and /or that treatment was provided to the area from 8/15/07 through 8/28/07.

h. Resident #21 was admitted to the facility on 6/22/07 with diagnoses of brain mass, weakness/fatigue and thrombocytopenia. An admission assessment dated 6/26/07 identified that the resident was cognitively impaired, required extensive assistance from staff for mobility and ADL's, was incontinent of bowel, had a Foley catheter, and had no pressure sores. The care plan dated 7/5/07 identified the potential for altered skin integrity. Interventions included to keep pressure off heels while in bed, and to change body position every 2 hours. On 7/14/07, the care plan noted to treat the heel as ordered. On 7/15/07, the care plan directed the application of gel socks to both feet. A care plan dated 7/17/07 identified the resident had a stage two of the left heel and a stage one of the right heel. Interventions included to avoid friction and sheering and to keep pressure off the heels while in bed. Nursing notes dated 7/14/07 noted that the resident had been observed moving the lower extremities and digging heels into the bed. Ativan was given. At 11 AM, the nurse aide reported that the resident's left heel had an open area. The area appeared as an open blister. The nurse aide placed a pillow under the resident's calves to relieve pressure. A physician order dated 7/14/07 directed the application of Bacitracin twice a day. The APRN wound assessment dated 7/17/07 identified that on 7/14/07 the resident developed a stage 2 of the left heel that measured 4 by 4.3 cm with a purple discoloration, and a stage one of the right heel that was noted to be red and boggy. On 7/31, the APRN assessment noted that the resident's right heel has an unstageable, soft black area with the edges lifting. Accuzyme was ordered. Interview and review of the clinical record, nurse's notes, and treatment kardexes with the Corporate Nurse on 9/12/07 at 2 PM failed to provide documentation/evidence that interventions had been implemented to prevent the resident's heels from breaking down and/or that new interventions were initiated when the resident's wounds declined.

i. Resident #23's diagnoses included obesity, diabetes, and cellulitis. A quarterly assessment dated 5/9/07 identified the resident was without cognitive impairment, required extensive assistance from staff for all ADL's, was incontinent of bowel and bladder and was without pressure sores. The care plan dated 5/15/07 identified the potential for alteration in skin integrity. Interventions included to provide pressure redistribution mattress/overlay as needed. Nurse's notes dated 5/28/07 identified the resident developed a stage two open area between the buttocks measuring 4-5 cm long and 0.5 cm wide. Observation of the resident on 9/12/07 at 2:40 PM during wound care noted the resident to have a stage two area between the buttocks that measured 6.5 by 4 cm. The resident was noted to be on an extra large bed that had a regular vinyl covered

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mattress in place. Interview and review of the clinical record with the ADNS on 9/12/07 at 2:20 PM and observation of the resident's mattress noted that the mattress was not pressure reducing. Further review failed to provide evidence that the resident had been placed on a repositioning program. Review of wound documentation at that time noted that the wound lacked assessment from 8/17/07 through 9/7/07. Review of the care plan failed to provide evidence that a care plan had been developed to address the resident's pressure sore until 8/7/07.

j. Resident #11 was admitted to facility on 08/10/07 with diagnoses that included generalized weakness and dementia. A nursing admission assessment dated 08/10/07 identified the resident's right heel pressure sore as a "black area" that measured 4.2 CM X 2.2 CM and the left heel as a "black area" that measured 7.0 CM X 5.3 CM. An initial assessment dated 08/17/07 identified that the resident was cognitively impaired, required extensive assistance with all ADL's including bed mobility, was incontinent of bowel and bladder, and had one stage II and two stage IV pressure ulcers. The care plan dated 08/10/07 identified a stage II pressure ulcer on the coccyx, and right and left heel "black areas." Interventions included "daily pressure ulcer monitoring by licensed nurse to include dressing status", pressure off heels in bed and to reposition/off load pressure every two (2) hours. An assessment by the APRN dated 08/15/07 identified the right heel with an unstageable pressure sore that measured 4.6 CM X 2.5 CM and the left heel with an unstageable pressure sore measuring 4.5 CM X 5.5 CM, each described as having a hard, black eschar. Review of physician orders failed to identify any treatment orders and/or direction for care of the resident's bilateral heels from 8/10/07 until 08/15/07. Physician orders dated 8/15/07 directed skin prep to both heels. A subsequent order dated 9/4/07 directed Silvadene and a dressing to the right heel and continue skin prep to the left heel twice a day. Continuous observation of the resident from 7:35 AM to 10:36 AM (3 hours one minute) on 9/10/07 noted the resident in bed on his/her back, with both feet flat (lacking floating off the surface of the bed). Subsequent to surveyor inquiry at 8:15 AM, the charge nurse removed the covers to observe the resident's heels with the surveyor and noted the resident's right outer, lateral heel and left inner lateral heel were resting directly on the mattress/bed without the benefit of offloading pressure on the heels and/or gel socks or other protective devices in place. The right heel was without the benefit of any kind of dressing as directed. Despite surveyor inquiry regarding the resident's heels without the benefit of pressure reduction and a dressing, the charge nurse left the room, and the resident remained without the benefit of off loading pressure on the heels and/or a dressing to the right heel wound until 10:36 AM. During an interview and observation of resident's room with the unit charge nurse and the ADNS on 09/10/07 at 2:30 PM she indicated that she was aware the resident required a dressing to the right heel but was unable to do the treatment until the resident returned from physical therapy. She noted that she had called supply for a new pair of gel socks at that time. Subsequent to surveyor inquiry the ADNS found the resident's gel socks in the bedside dresser drawer. Review of the clinical record with the ADNS at that time failed to provide evidence that the resident's heel wounds were provided with

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any treatments and/or interventions to alleviate pressure from admission on 8/10/07 through 8/15/07.

k. Resident #22's diagnoses included urinary tract infection, urosepsis, and dementia and legally blind. A quarterly assessment dated 07/13/07 identified the resident as having short term memory problems and total dependence on staff for all activities of daily living (ADL) including bed mobility. It further identified that the resident was incontinent of bowel and bladder and had no problems with skin integrity. The resident care plan (RCP) dated 07/24/07 identified a problem with skin integrity related to very fragile skin and a skin tear. Interventions included to turn and reposition every two hours and as needed. A nursing re-assessment dated 09/07/07 identified a cut on the resident's right great toe, a skin tear on the left shin, a bruise on left forearm and no other skin integrity problems. A pressure ulcer risk assessment tool dated 09/07/07 identified that the resident was at high risk for skin breakdown. Observation of the resident on 09/10/07 identified that the resident was transferred out of bed via a Hoyer lift with the assist of two nurse aides at 10:15AM. Subsequent to surveyor inquiry on 09/10/07 at 1:00 PM, regarding Resident #22's return to bed, the Nurse Aide (NA) stated "Hoyers go back to bed at 2:00 PM." Additionally, an interview with the two (2) NA's caring for the resident on 09/10/07 at 1:40 PM, identified that the resident had not been back to bed since that morning (period of three hours and forty five minutes). Observation of the resident receiving incontinent care on 09/10/07 at 1:44 PM identified an open area on the coccyx. The NA indicated that she would tell the nurse. Further observation noted the resident's peri-area and buttocks were reddened with deep lines of imbedded demarcation on the buttocks. Although the NA indicated on 9/10/07 that she would inform the nurse of the open area on the coccyx, review of the clinical record on 9/11/07 failed to identify that the physician had been notified and/or the area had been assessed. Subsequent to surveyor inquiry an assessment of the resident's coccyx area was completed by the Director of Nursing (DNS) and APRN which identified a pressure ulcer located on the coccyx that measured 2.0 CM X 0.5 CM. An interview and review of the resident's clinical record with the Director of Nursing (DNS) on 09/11/07 at 2:30 PM failed to provide evidence that the physician had been notified and/or a treatment obtained for the open area on the coccyx. During an interview with the unit Charge Nurse on 09/12/07 at 7:22 AM, she indicated that she could not recall whether she had been informed of the resident's change in skin condition.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (m) Nursing Staff (2)(O).

11. Based on clinical record reviews, observations, and interviews for two of eighteen sampled residents who were incontinent of bladder (R#7, 22), the facility failed to assess the resident ' s decline in continence/initiate a retraining program, and/or failed to provide appropriate, and timely incontinent care in a resident with a recent history of hospitalization for urosepsis, to prevent further

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bladder infections. The findings include:

a. Resident #22 ' s diagnoses included urinary tract infections (UTI), urosepsis, dementia, and legal blindness. A quarterly assessment dated 7/13/07 identified the resident as having short term memory problems, totally dependent on staff for all activities of daily living (ADL) including bed mobility, was totally incontinent of bowel and bladder, and had no problems with skin integrity. The resident care plan (RCP) dated 07/24/07 identified the potential for alteration in skin integrity related to urinary and fecal incontinence. Interventions included skin care per protocol following each incontinent episode. A hospital admission history and physical dated 9/3/07 identified that the resident was admitted with a temperature of 103.5 and diagnosed with urinary tract infection, urosepsis, and dehydration. The resident was re-admitted to the facility on 9/5/07. Observation on 09/10/07 at 10:07 AM noted the resident had just completed receiving morning care. At 10:15 AM, the resident was transferred out of bed to a wheelchair with a mechanical lift (Hoyer) by two (2) nurse aides (NA). Observation of the resident receiving care on 09/10/07 at 1:44 PM, noted that the resident ' s brief was saturated. The NA ran water in the bathroom sink, took a towel, wet a corner of the towel with water, and then poured peri-wash onto that corner. The NA washed the anterior pubic area, turned the resident to the side and wiped over the surface of buttocks, over the resident ' s rectal area, and up through an open area (sore) on the coccyx. The perineal/urethral area was never washed. Interview with NA ' s caring for resident on 09/10/07 at 1:40 pm indicated that the resident had not been back to bed/received any incontinent care/checks since getting out of bed that morning (total of 3 hours and 25 minutes). They noted that Hoyer lift residents get out of bed in the morning and go back to bed at 2 PM.

b. Resident #7 ' s diagnoses included Alzheimer ' s disease. A quarterly assessment dated 1/6/07 identified the resident was without cognitive impairment, dependent on staff for bathing and dressing and was continent of bowel and bladder. The care plan dated 3/4/07 identified the resident had become incontinent of bowel and bladder. Interventions included planning and implementing a bowel and bladder rehabilitation program. Observation of the resident on 9/11/07 at 10 AM noted the resident had been incontinent of urine. The nurse aide performing the care at that time, noted that the resident was " always incontinent now ". The care card/nurse aide assignment identified that the resident was continent of both bowel and bladder. Interview with the corporate nurse and review of the clinical record on 9/11/07 at 2 PM failed to provide evidence that the bowel and bladder rehabilitation program had been initiated/attempted when the resident ' s bladder continence declined.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (k) Nurse Supervision (1).

12. Based on clinical record review, observation and interview for one of three sampled residents with contracted lower extremities (R#3), the facility failed to reassess the resident ' s need for therapy

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services and/or devices to prevent further decline, when the resident was noted to be pulling up the lower extremities, resulting in a stage IV pressure sore of the foot. The findings include:

a. Resident #3's diagnoses included dementia, depression, and tube feeding. A quarterly assessment dated 5/18/07 identified that the resident was cognitively impaired, totally dependent on staff for Activities of Daily Living (ADL's), and had two stage two pressure sores. The care plan dated 7/31/07 noted a problem with positioning related to the resident pulling up the legs and feet under the buttocks. Interventions included repositioning to prevent skin to skin contact, and to obtain an occupational therapy (OT) screen for positioning in bed and the wheelchair. Observations on 9/10/07 at 7:33 AM noted the resident in bed, with the knees flexed/contracted. At 11:32 AM during provision of incontinent care, the resident was noted to have very contracted lower extremities, with both knees drawn up. The Nurse Aides providing care had difficulty cleansing the resident due to the inability to straighten/move the legs. Interview with the Charge Nurse on 9/11/07 at 1 PM identified that the resident pulls the left leg/foot up behind the right calf causing the (outside of the left foot) to be flat on the bed. Observations on 9/11/07 at 2:16 PM noted the resident ' s left lateral foot had an approximately 8 cm long open area with muscle and tendon visible at the top and soft tissue along the base. Interview on 9/13/07 at 12:34 PM with the Wound Nurse noted that muscle and tendon exposed are considered a stage IV pressure sore. Interview with the Director of Rehabilitation on 9/11/07 at 12:12 PM noted that they had not received any referrals from nursing related to positioning assistance for Resident #3. Subsequent to surveyor inquiry, an OT screen was completed. The Director of Rehab noted that the resident's lower extremities had declined in range of motion (contractures) from 75% to 50% since January 2007 when last screened. Interview and review of the clinical record on 9/12/07 at 8:07 AM with the MDS coordinator noted that although she was certain she had communicated to OT and requested a screen, she was not able to provide documented evidence that an OT screen was requested. Interview on 9/13/07 at 2:05 PM with the Director of Rehabilitation noted that although he was aware that the resident had positioning problems, subsequent to surveyor inquiry on 9/11/07 and needed OT services, an order from the physician for an evaluation had not been obtained and therefore the evaluation not completed. Following surveyor inquiry, the Director of Rehabilitation noted that the nurse obtained the physician order and the resident would be assessed 9/13/07.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (m) Nursing Staff (2)(C).

13. Based on clinical record reviews, observations, review of facility reports/investigations, and interviews for 3 of 6 sampled residents with injuries of unknown origin and/or combative behaviors (R#6, 12, 22), the facility failed to ensure that interventions developed to prevent injuries were implemented, and/or that resident ' s known to be physically abusive to other resident ' s were appropriately supervised, and/or that the environment was maintained in a safe manner to prevent

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accidents. The findings include:

a. Resident #6's diagnoses included Alzheimer's disease and depression. The quarterly assessment dated 3/29/07 identified the resident was cognitively impaired, had a behavioral symptom of wandering, and required extensive assistance for activities of daily living including locomotion on/off the unit. The care plan dated 5/10/07 noted the resident unknowingly invades others space when self-propelling in the wheelchair and behavior at times can annoy or agitate other residents. Interventions included staff will observe and intervene as necessary to maintain resident safety. Nurse ' s notes dated 6/5/07 at 4:30 PM noted the resident continues to go into others rooms, often upsetting other residents, becoming verbally aggressive and refusing to leave. Nurse ' s notes dated 6/8/07 at 6:15 PM noted the resident wandered into Room 218, and when asked to leave by two other residents, he/she kicked one resident in his/her right leg/right knee lightly, and the other resident reportedly in his/her left great toe. It further noted the resident was confused, intrusive, wanders throughout the unit, and the family has been contacted by social worker regarding a room change to 3W. Physician's progress notes dated 6/11/07 noted the resident was status post incident 3 days ago where the resident allegedly kicked one resident on the knee and leg and another resident on the foot, and noted the resident wanders around the 2nd floor frequently and gets into other resident's rooms. She further noted the resident would be transferred to another unit. Notes dated 6/12/07 by Social Services identified that the prior week, a message was left for the son requesting a room change secondary to ongoing intrusive behavior into other resident's rooms, and that a family member had approved the change. It further noted Social Services agreed to a room change on 6/12/07 to room 330 and nursing was informed. A note dated 6/14/07 by social services identified that the resident did not change rooms and staff were going to try and manage the intrusive behaviors for another week. Nurse's notes dated 7/12/07 at 4:30 PM noted that R#6 allegedly kicked another resident twice in the left foot. 15 minute checks were initiated. A behavioral health progress note dated 7/19/07 recommended to restart Risperdal, for safety, erratic combative behavior, and occasional altercations with peers. Nurse ' s notes dated 8/28/07 at 7:15 PM noted resident became violent; hitting another resident. Nurse ' s notes dated 9/8/07 noted that at 5:15 PM, another resident claimed that R#6 was behind him, held the wheel of his chair, and caused the chair to tip and fall. Observation on 9/10/07 at 12:58 PM noted the resident self-propelling in a wheelchair down the hallway and around the unit. A group interview with residents held on 9/10/07 identified that multiple residents voiced concern regarding the behaviors of R#6, including some who voiced fear regarding the resident ' s actions. Interview on 9/12/07 at 10:30 AM with the social worker noted she was aware that the resident wandered, and that the other residents became upset with R#6 wandering into their rooms. She further noted that R#6 was to be transferred up to the third floor, however the aides protested, and R#6 was kept on the same unit with the staff ' s assurance that they would keep an eye on him/her. The social worker was unable to provide documentation of close monitoring and/or a care plan to address the prevention of further altercations and/or to maintain other residents

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safety. She noted that although she would be made aware of resident to resident altercations through clinical report, she was not made aware that this resident became angry, lashed out at anyone, and/or having continued altercations with residents since early 7/07. Interview on 9/12/07 at 12:12 PM with the DNS identified the resident was going to be transferred to 3W (a dementia unit), but when she spoke with the staff, they decided not to transfer the resident. She noted that the staff were to closely monitor by redirecting the resident. The DNS was unable to provide evidence of close monitoring of behaviors and/or supervision to ensure the safety of other residents.

b. Resident # 22 ' s diagnosis included dementia and legal blindness. An admission assessment dated 04/18/07 and quarterly assessment dated 7/13/07 identified the resident was cognitively impaired, totally dependent on staff for all activities of daily living, and had other skin problems that included abrasions, bruises and skin tears or cuts. Physician orders dated 04/11/07, 04/12/07 and 06/14/07 directed the application of geri-sleeves (protective sleeves) to all extremities secondary to fragile skin. Review of nurse ' s notes and/or facility documentation identified that the resident sustained skin tears as follows:

   i. forehead on 04/30/07
   ii. right hand on 06/02/07
   iii. left lateral knee on 06/03/07
   iv. laceration to right knee on 07/16/07
   v. left lower leg on 08/29/07.

   Documentation was lacking both in the investigations and/or clinical record to provide evidence that geri-sleeve skin protection had been utilized as ordered. Observation of the resident on 09/10/07 at 10:27 A.M. and on 09/11/07 at 1:39 P.M. with the director of nursing (DNS) noted the resident without the benefit of geri-sleeves or other protection, on any extremities. Subsequent to surveyor inquiry on 09/11/07, the DNS located the resident ' s personal upper and lower geri-sleeve skin protection in the resident ' s dresser drawer. Review of the clinical record, facility documentation and care plan with the DNS failed to provide evidence that assessments into the origin of the injuries had been thoroughly conducted, and/or that interventions were developed and/or implemented to prevent injuries to the resident.

c. Resident #18 was admitted to the facility on 6/13/07 with diagnoses that included paraplegia, transverse myelitis, and recurrent pressure ulcers. The admission nursing assessment dated 6/13/07 identified that the resident utilized an electric wheelchair for mobility. Observation on 9/12/07 at 10:20 AM noted the electric wheelchair in the resident ' s room with a light on indicating it was charging. The Maintenance Staff present told the nurse to relocate and plug the wheelchair into the electrical receptacle in the corridor. Subsequent to surveyor inquiry, interview at 10:40 AM with the Maintenance Staff noted he was unaware the electric wheelchair could not be charged in a resident ' s area. He noted he would charge the wheelchair in a non- resident area. During observation of a wound treatment on 9/12/07 on 1 East at 10:00AM, the licensed nurse left the treatment cart unlocked and unattended with the draws open in the

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hallway.

d. Resident #12 was admitted to the facility on 6/22/07 with diagnoses that included status post total right hip replacement. An admission assessment dated 6/29/07 identified that the resident required extensive assistance with two persons for bed mobility, transfer and had abrasions and bruises. The care plan updated 7/26/07 identified the problem of a skin tear to the left elbow with interventions that included a treatment to the area. The care plan dated 7/30/07 identified a skin tear to the right hand. Interventions included padding the side rails. A nursing note dated 7/30/07 noted a skin tear on the right. A facility report dated 7/30/07 identified that an area of purpura on the right hand had opened. Observation of the resident in bed on 9/10/07 from 7:15 AM-11:45 AM noted the resident in a short sleeve hospital gown, without the benefit of padded side rails or protective coverings to the arms and hands. The resident's left hand and 3rd finger were noted to be ecchymotic/discolored. Observation of the resident out of bed at noon, noted the resident in a short sleeve shirt and shorts. Interview and review of the clinical record with the Care Plan Coordinator on 9/11/07 at 2:00 PM failed to provide documented evidence that interventions were implemented to protect and/or prevent further skin tears.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (n) Medical and Professional Services (5)(A).

14. Based on clinical record reviews, and interviews for two of thirty sampled residents (R#7, 9), the facility failed to ensure that the resident ' s attending physician visited at least once every 60 days, and/or that physician visits alternated with physician extender visits (APRN). The findings include:

a. Resident #7 ' s diagnoses included Alzheimer ' s disease. Review of physician progress notes and/or orders dated from 2/13/07 through 8/13/07 with the corporate nurse on 9/11/07 at 2 PM noted that although the facility APRN had assessed the resident during that time, the physician had not documented a visit for 6 months. Resident #9 ' s diagnosis included dementia. Review of physician orders for 05/07, 6/07 and 7/07 identified that all three month ' s orders were signed by physician on 08/22/07. Review of physician progress notes identified a visit on 4/4/07 with the next visit dated on 08/22/07. The facility was unable to provide evidence that the physician had visited/assessed the resident at least once every 60 days or that the medical director had been asked to intervene.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (t) Infection Control(2)(A).

15. Based on clinical record review, observations, and interview for one of 12 sampled residents observed receiving incontinent care (R#11) and/or for one of three sampled residents on isolation precautions (R#30), the facility failed to ensure that proper handwashing, linen handling, trash removal/storage, and/or environmental contamination prevention mechanisms were in place in

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THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

accordance with isolation guidelines, and/or that infection prevention/transmission standards were maintained, and/or that an infection control program was in place. The findings include:

a. Resident #11 ' s initial assessment dated 08/17/07 identified that the resident was cognitively impaired, required extensive assistance with all ADL ' s including bed mobility, and was incontinent of bowel and bladder. On 09/10/07 at 10:36 A.M., a NA brought the resident into the bathroom, which was shared with another resident, directed the resident to stand at the toilet, and removed the brief removed which was noted to be full of loose stool. Loose stool was noted dripping from the resident ' s perineal area, covering and dripping from the scrotum. After removing the soiled brief, the NA filled the sink with water, and placed a washcloth into it. She added body wash (soap) into the sink water, and proceeded to wash the resident ' s upper body and extremities, using the soap and water from the sink. The NA wiped excess stool from the resident ' s groin and then utilized toilet paper to wipe (after Johnny coat). Utilizing a towel and water from the sink, the NA was then noted to continue to wipe between the resident ' s legs. During an interview with the infection control nurse at approximately 12:45 PM she indicated that incontinent care should be provided utilizing a personal wash basin.

b. Review of the infection control program with the former infection control nurse, and the corporate nurse identified that the facility lacked an adequate infection control program as evidenced by the following:

   i. Environmental surveillance rounds were not available for 2007.
   ii. An accurate, current line listing for all residents with a history of multi-drug resistant bacteria was not maintained.
   iii. Monthly infection statistics were not available for all months of 2007.

   Interview with the infection control nurse on 9/24/07 at 10 AM noted that she had been re-assigned to do all the wound care and the assistant director of nursing and was unable to keep up with the assignments.

c. Resident #30's diagnoses included C-Difficile (C-Diff) stool infection, MRSA of the nares, and urinary tract infection. The care plan dated 8/27/07 identified the problem of a C-diff stool infection. Interventions included to maintain contact precautions. Observation on 9/12/07 at 9:50AM during morning care and 10:00AM during a wound treatment noted the nurse and nurse were gowned in protective equipment (gowns, gloves and mask). The resident had been incontinent of stool, which was noted to be underneath the wound dressing. Observations noted that the resident ' s bathroom contained a small waste basket that was overflowing with soiled protective gowns and gloves approximately 2 feet above the basket and on the bathroom floor. The bathroom was shared with three other residents. Subsequent interview and observation with the Corporate Nurse immediately following noted that the bathroom would be cleaned and the appropriate isolation containers would be supplied.

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THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (k) Nurse Supervision (I) and/or (t) Infection Control (2)(A).

16. Based on clinical record review, observation, and interview, the facility failed to ensure that gloves were removed and hands washed after coming in contact with potentially infectious body materials and/or before touching environmental objects. The findings include:
    a. Observation on 9/10/07 at 9:20 AM noted that Resident #27 had been incontinent of urine and stool and the nurse aide provided incontinent care. Without removing the gloves or washing hands, the nurse aide was observed applying barrier cream, touching the bedside drawer handle, touching the overbed table, touching the resident ' s electric shaver, and placing soiled linen into the cart in the hallway. The nurse aide then removed the gloves, obtained a Hoyer lift from the hallway, and brought it into the resident ' s room prior to washing hands and donning clean gloves. Interview with the Nurse Aide on 9/10/07 at 2:40 PM noted her general practice was to remove gloves between soiled and clean functions, however she was not aware she needed to wash her hands
    b. Resident #30's diagnoses included C-Difficile (C-Diff) stool infection, MRSA of the nares, and urinary tract infection. The care plan dated 8/27/07 identified the problem of a C-diff stool infection. Interventions included to maintain contact precautions. Observation on 9/12/07 at 9:50AM during morning care and 10:00AM during a wound treatment noted the nurse and nurse were gowned in protective equipment (gowns, gloves and mask). The resident had been incontinent of stool, which was noted to be underneath the wound dressing. Observation of the licensed nurse during the coccyx wound treatment noted that the soiled dressing was removed, and put into a plastic bag. The nurse removed her gloves, and without washing her hands, walked to the doorway, and proceeded to attempt to open the treatment cart. Subsequent to surveyor inquiry, the nurse stopped and washed hands prior to obtaining supplies from the treatment cart.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2)(K).

17. Based on review of personnel files and interviews for seven nurse aide files reviewed, the facility failed to ensure that the nurse aides received at least 12 hours of continuing education per year, and/or failed to ensure that the nurse aides received annual performance evaluations. The findings include:
    a. Interview and review of personnel files on 9/21/07 at 1:20 PM with the human resource coordinator, failed to provide evidence that six nurse aides who had been employed greater than one year, had received performance evaluations annually.Interview and review of inservice records for seven nurse aides who had been employed more than one year on 9/21/07 at 12:30 PM with the staff development coordinator, failed to provide evidence that any of the nurse aides had attained the mandatory 12 hours of continuing

EXHIBIT A
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THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

education classes for the year.

EXHIBIT B
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FLIS Independent Nurse Consultant Guidelines

Relationship between Independent Nurse Consultant (INC) and DPH includes:

- An INC is utilized as a component of DPH's regulatory remedy process. An INC may be agreed upon as a part of a Consent Order between the institution and the Department when significant care and service issues are identified.
- The INC has a fiduciary or special relationship of trust, confidence and responsibility with the Department.
- The INC's responsibilities include:
  - Reporting to the Department issues and concerns regarding quality of care and services being provided by the institution.
  - Monitoring the institution's plan of correction to rectify deficiencies and violations of federal/state laws and regulations. Reports to Department positive and negative issues related to said oversight.
  - Assessing administration's ability to manage and the care/services being provided by staff.
  - Weekly reporting to the Department of issues identified, plans to address noncompliance and remediation efforts of the institution.